STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001147	A. BUILDING: _____ B. WING _____	C 04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY REST HOME	10924 LINCOLNWAY E PLYMOUTH, IN 46563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This survey was for the Investigation of Complaint IN00146361. Complaint IN00146361-Unsubstantiated due to lack of evidence. Survey date: 04/17/14 Facility number: 001147 Provider number: N/A AIM number: N/A Survey team: Honey Kuhn, RN Census bed type: Residential: 43 Total: 43 Census payor type: Medicaid: 42 Other: 1 Total: 43 Sample: 3 Shady Rest Home was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00146361. Quality Review 04/17/14 by Lisa McColly	R 000		